CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

DMAS routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. DMAS may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the

provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 East Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free HELPLINE is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: 1-804-786-6548
CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his/her name and telephone number in case DMAS has questions regarding the referral.

COMMUNITY MENTAL HEALTH, CASE MANAGEMENT, AND SUBSTANCE ABUSE SERVICES

Utilization Review (UR) - General Requirements

Utilization Reviews of enrolled providers of community mental health, case management, and substance abuse services are conducted. These reviews may be unannounced. During each review, an appropriate sample of the provider's total Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization Review (UR) is comprised of desk audits, on-site record review, and may include observation of service delivery. It may include face-to-face or telephone interviews with the consumer, family, or significant other(s), or both. Providers may be asked to bring program and billing records to a central location.

The review shall include the following items:

- The appropriateness of the admission to service and for the level of care;
- The medical or clinical necessity of the delivered service;
- A copy of the provider's license/certification, staff licenses, and qualifications for Licensed Mental Health Professional (LMHP), Qualified Mental Health Professional (QMHP), and paraprofessionals to ensure that the services were provided by appropriately qualified individuals as defined in Chapter II of this manual;
- Ensure documentation supports QMHP supervision of qualified paraprofessionals as

set forth in Chapter IV;

- Ensure that entry level paraprofessionals are paired with a qualified paraprofessional and supervised by a QMHP as set forth in Chapter IV;
- A current, signed Individualized Service Plan (ISP) detailing the need for the specific services;
- Documentation that the client is involved, to the extent of his/her ability, in the development of the ISP; and
- A determination that the delivered services as documented are consistent with the recipient's Individualized Service Plan (ISP), invoices submitted, and specified service limitations.

Services must meet the requirements set forth in 12 VAC 130-540 through 590 and in the Virginia *State Plan for Medical Assistance Services* and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine UR, review staff will be available to meet with provider staff. The purpose of the Exit Conference is to provide a general overview of the UR findings, preliminary actions required, recommendations that may help the provider correct problems, or documentation.

Following the review, a UR written report of the findings is sent to the provider. Any infractions will be cited in the written report and may result in billing retractions, voids to continued billing, or a request for a Plan of Correction. If a billing adjustment is needed, it will be specified in the written report along with a timeline for submitting the adjustment. If a Plan of Correction is requested, the provider will have 30 days (unless otherwise indicated) from receipt of the UR report to submit the plan for approval.

Findings identified in the written report are subject to a request from the provider for reconsideration. The procedures for submitting a request are specified in the cover letter that accompanies the written UR report and must be completed within 30 days from receipt of the letter.

DOCUMENTATION REQUIRED FOR COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES AND CASE MANAGEMENT SERVICES

The Provider Agreement requires that records fully disclose the extent of services provided to Medicaid consumers. Records must clearly document the medical or clinical necessity and support needs for the service. This documentation must be written at the time the service is rendered, must be legible, and must clearly describe the services rendered.

To describe the service, review the service description, select the procedure code in Chapter V of this manual which most appropriately describes the service rendered and documented, and enter the appropriate procedure code in the record. The service descriptions will be used to evaluate the documentation during audits of records. The following elements are a clarification of

Medicaid policy regarding documentation:

- The consumer must be referenced on each page of the record by full name or Medicaid consumer number.
- The record must contain a preliminary working diagnosis and a psychiatric/psychological assessment upon which the diagnosis or ISP is based.
- Recipients should be referred for a physical examination. The results of the physical examination shall be a part of the mental health record.
- An assessment of adaptive functioning is recommended to support medical necessity criteria.
- The ISP must be part of the record.
- The enrolled provider must develop and maintain written documentation for each service billed. Adequate documentation is essential for audits of billed services. The documentation must include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units required to deliver the service. A log sheet is recommended for recording this information. Documentation of supervision is set forth in Chapter IV of this manual.
- Progress notes are also part of the minimum documentation and are to convey the consumer's status, staff interventions, and, as appropriate, progress toward goals and objectives in the ISP. Progress notes must be entered for each service that is billed.
- Any drugs prescribed as a part of the treatment, including the prescribed quantities and the dosage, must be entered in the record.
- A recipient-signed document verifying freedom of choice of provider was offered and this provider was chosen.

MENTAL HEALTH SERVICES

Intensive In-Home Services for Children and Adolescents (H2012)

Admission to Service Was Appropriate

The reviewer determines whether the child or adolescent (under age 21) is at risk of being moved into an out-of-home placement or is being transitioned to home from an out-of-home placement due to the clinical needs of the individual.

Services far more intensive than outpatient clinic care are required to stabilize the family situation, or the client's residence as the setting for service is more likely to be successful than a clinic. Service is not appropriate for families when the child is absent from the home or for families being kept together until an out-of-home placement for the child can be made.

Medical/Clinical Necessity

At admission, a face-to-face assessment by a LMHP, or by the QMHP and approved by the LMHP within 30 days, documents the need for the service. A comprehensive Individualized Service Plan (ISP) is completed by a QMHP within 30 days of the initiation of services demonstrating the need for a minimum of three hours per week of intensive in-home services. The ISP should indicate, in specific terms, the activities of both the client and the staff. For each goal/objective, the following information should be stated: why the goal/objective is needed (a problem/need statement); the desired outcome for a particular goal/objective; strategies for service intervention; the staff person responsible for service intervention; a target date for accomplishment of the goal/objective; and the planned frequency of staff activity.

Service Provided by Qualified Provider

This review is to ensure that the agency is licensed by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), and that appropriate staff conduct any assessment or evaluation, develop the ISP, and deliver the service.

Intervention Meets Service Model Criteria (Additional Standards)

- The reviewer confirms from review of case documentation that the majority of services are delivered in the home.
- The reviewer confirms from a review of case documentation that a parent or guardian is an active participant in the services.
- The reviewer confirms that the ISP demonstrates the need for a **minimum** of three hours a week of Intensive In-Home Service with variations in service delivery to be consistent with the objectives of the service plan. This includes discharge planning identifying transition from In-Home Services.
- The reviewer confirms that delivered service is consistent with the ISP.

- The reviewer confirms that the maximum staff-to-caseload ratio fully meets the needs of the individual.

- The reviewer examines the ISP and progress notes to determine whether intensive in-home services were delivered in accordance with the ISP. Progress notes must clearly reflect behaviors, activities, and treatment methodologies that indicate attention to and movement toward stated goals and objectives in the ISP.

Delivered Services Consistent with Invoices

- The reviewer determines that the type and units of service billed match the documented service delivered. Dates, types, and units of service as recorded on the DMAS billing report are compared against documented services as noted on the case action sheet or progress notes.

- Documentation must include the date of service, the service or activity provided, signature and credentials, and the amount of service delivered. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted. If documentation is present but the number of units of service delivered does not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

- The reviewer determines that progress notes for intensive in-home services are completed when services are delivered.

Therapeutic Day Treatment for Children (H0035 Modifier HA)

Admission to Service Was Appropriate

The reviewer determines whether the child or adolescent meets the clinical criteria for the services. Information on the face sheet, diagnostic form, or ISP must be supported by clinical documentation such as psychological evaluations, copies of psychiatric hospital discharge summaries, social histories, and other evaluative information.

Medical/Clinical Necessity

- A diagnostic assessment conducted by an LMHP or by a QMHP, which is authorized by an LMHP, must demonstrate the need for the services. Documentation must be completed prior to the initiation of services.

- An ISP must be fully completed by the QMHP or the LMHP within 30 days of the initiation of services documenting the need for the service.

- The ISP should indicate, in specific terms, the activities of both the client and day treatment staff. For each day treatment goal or objective, the following information should be stated: why the goal or objective is needed (a problem/need statement); the desired outcome for a particular goal or objective; strategies for service intervention; the staff person responsible for service intervention; a target date for accomplishment

of the goal or objective; and the planned frequency of staff activity.

- The reviewer confirms by examination of progress notes, the Authorization for Service form, or both, that the services were authorized by a LMHP. The signature and corresponding licensure/credentials of the person authorizing the service must be clearly documented in order for this criterion to be satisfied.

Service Provided by Qualified Provider

The agency must be licensed by DMHMRSAS as a day treatment program. This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct any assessment or evaluation, develop the ISP, and deliver the service.

- The reviewer confirms that the programs operate a minimum of two hours per day and may include flexible hours, before or after school, and in the summer. The reviewer will examine the formal program description, review records of the hours of operation and program activities, and, when appropriate, conduct interviews with program staff.

Delivered Services Consistent with Service Plan

- The reviewer examines the progress notes and the ISP to determine that therapeutic day treatment services were delivered in accordance with the ISP. Progress notes must clearly reflect behaviors, staff activities, and treatment modalities that indicate attention and movement toward the stated goals and objectives in the ISP.

- The reviewer confirms that the staff-to-child ratio is adequate to meet the client's needs as identified in the ISP. The reviewer may examine staffing patterns, staff attendance data, program attendance data, interview program staff, and other resources, which document that an adequate ratio is maintained.

Delivered Service Consistent with Invoices

- The reviewer determines that the type and units of service billed match the documented service delivered. The dates, types, and units of service recorded on DMAS billing reports are compared against documented services as noted on the case action sheet, daily attendance logs, and progress notes. The documentation must include the date of service, the service or activity provided, the arrival and departure time of each client to and from the program, the amount of service delivered, and a staff signature. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted. If documentation is present, but the number of units of service delivered does not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

- The reviewer determines that the progress notes are completed on a weekly basis at a minimum.

Community-Based Residential Services for Children and Adolescents under 21 (Level A) H2022 with Modifier HW (CSA) or HK(non-CSA)

Admission to Service Was Appropriate

The reviewer determines if the child or adolescent meets admission criteria and that services could not be provided in a less restrictive setting.

Meets Medical Necessity Criteria

The reviewer determines that at least two areas of moderate impairment were identified and that the child participates in psycho-educational activities as well as individual psychotherapy. An assessment that identified the need for the service was performed by the Family Assessment and Planning Team (FAPT) for Comprehensive Services Act (CSA) children or by an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screener and a LMHP for non-CSA children.

Services Provided By Qualified Provider

This review is to ensure that the agency is licensed by the Department of Social Services (DSS), the Department of Education (DOE), or the Department of Juvenile Justice (DJJ), and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service.

Delivered Services Consistent with Invoices

The reviewer determines whether the type and units of service recorded on the DMAS billing report match the documented services as noted in the client record. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted. If documentation is present but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) H2020 with Modifier HW (CSA) or HK (non-CSA)

Admission to Service Was Appropriate

The reviewer determines if the child or adolescent meets admission criteria and that services could not be provided in a less restrictive setting.

Meets Medical Necessity Criteria

The reviewer determines that at least two areas of moderate impairment were identified and that the child participates in psycho-educational activities as well as individual and group psychotherapy. An assessment that identified the need for the service was performed by the FAPT for CSA children or by an EPSDT screener and a LMHP for non-CSA children.

Services Provided By Qualified Provider

This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service.

Delivered Services Consistent with Invoices

The reviewer determines whether the type and units of service recorded on the DMAS billing report match the documented services as noted in the client record. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted.

If documentation is present, but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

Day Treatment/Partial Hospitalization (H0035 Modifier HB)

Admission to Service Was Appropriate

The reviewer examines documentation to determine whether the client meets the definition for the service, indicating significant functional impairments due to mental, behavioral, or emotional illness (a DSM-IV diagnosis alone will not constitute sufficient documentation).

Medical or Clinical Necessity

- The reviewer confirms that a face-to-face evaluation by a LMHP, for the purpose of a diagnostic assessment, was made prior to the initiation of the service.
- An ISP must be fully completed by a QMHP within 30 days of service initiation documenting the need for the service.
- The ISP should indicate, in specific terms, the activities of both the client and the day treatment staff. For each day treatment goal or objective, the following information should be stated: why the goal or objective is needed (a problem/need statement); the desired outcome for a particular goal or objective; strategies for service intervention; the staff person responsible for service intervention; a target date for accomplishment of the goal or objective; and the planned frequency of staff activity.
- The reviewer examines corresponding progress notes or written evaluations, or both, to determine that service is authorized by a LMHP and is clinically/diagnostically indicated.
- Services must be terminated when other less intensive services may achieve or maintain psychiatric stabilization.

Service Provided by Qualified Provider

- The provider must be licensed by DMHMRSAS to operate Day Treatment Services.
- This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct any assessment or evaluation, develop the ISP, and deliver the service.
- The reviewer confirms, through examination of a formal program description and interviews with program staff, that the program operates a minimum of two continuous hours in a 24-hour period.
- The signature and corresponding license/credentials of the person giving authorization for the service must be clearly documented and legible in order for this criterion to be satisfied.

Delivered Service Consistent with Service Plan

The reviewer examines the ISP and progress notes to determine whether day treatment/partial hospitalization services were delivered in accordance with the ISP. Progress notes must clearly reflect behaviors, activities, and treatment methodologies which indicate attention to and movement toward stated goals and objectives in the ISP.

The reviewer confirms that a face-to-face evaluation and re-authorization (by a licensed professional) for continued service beyond 90 days occurred by the end of 90 days of client participation in day treatment/partial hospitalization services. The reviewer examines the documentation to verify that a face-to-face evaluation occurred.

Delivered Services Consistent with Invoices

The reviewer determines that the type and units of service billed match the documented service delivered. The dates, types, and units of service as recorded on DMAS billing reports are compared to the documented services as noted on the case action sheet, daily attendance logs, and progress notes. The documentation must include the date of the service, the service or activity provided, the arrival and departure time of each client to and from the program, the amount of service delivered, and a staff signature. If there is no documentation during the period for which services were billed to support the services that were delivered, payment in full will be retracted. If the documentation is present but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

The reviewer determines that the progress notes for Day Treatment/Partial Hospitalization Services are complete when services are delivered.

Psychosocial Rehabilitation (H2017)

Admission to Service was Appropriate

The reviewer will look first for documentation that the person has experienced long-term or repeated psychiatric hospitalization, experiences difficulty in activities of daily living (ADLs) and interpersonal skills, or whose support system is limited or non-existent. If this is not evident, the reviewer will request staff assistance in locating evidence that the person is unable to function in the community without intensive intervention or requires long-term care to remain in the community (this criteria may be met if there is documented evidence that the individual lacks daily living skills, lacks interpersonal skills and a support network, etc.). If none of the above criteria is found, this standard is unmet.

The LMHP must review services that last six months and document the continued need for the service. The ISP must be rewritten at least annually.

Persons with a substance abuse disorder would not be appropriate for psychosocial rehabilitation services unless there is also an identified (and diagnosed) mental health disorder and other criteria, as noted above, are met.

Medical or Clinical Necessity

An assessment by a LMHP or QMHP and approved by the LMHP must be documented to provide a basis for determining the client's current and potential strengths, weaknesses, and service/support needs, using formal or informal evaluation information and techniques.

A signed and dated ISP must be completed within 30 days of the service initiation by the QMHP, and must document that psychosocial rehabilitation services are needed. The ISP should indicate, in specific terms, the activities of both the client and psychosocial staff. For each psychosocial goal or objective, the following information should be stated: why the goal or objective is needed (a problem/need statement); the desired outcome for a particular goal or objective; strategies for service intervention; the staff person responsible for service intervention; a target date for accomplishment of the goal or objective; and the planned frequency of staff activity. Every three months, the LMHP or QMHP must review, modify as appropriate, and update the ISP.

Services Provided by Qualified Provider

- The agency must be licensed by DMHMRSAS as a psychosocial rehabilitation or clubhouse provider. This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service.

- The reviewer confirms, through examination of a formal program description and interviews with program staff, that the program operates a minimum of two continuous hours in a 24-hour period.

Delivered Service Consistent with Service Plan

The reviewer examines the ISP and progress notes to determine whether psychosocial rehabilitation services were delivered as outlined in the ISP. Progress notes must clearly reflect client behaviors and staff activities that indicate attention to and movement toward stated goals and objectives in the ISP.

Delivered Services Consistent with Invoices

The reviewer determines that the type and units of service billed match the documented service delivered. The dates, types, and units of service as recorded on DMAS billing reports are compared to documented services as noted on the case action sheet, daily attendance logs, and progress notes. The documentation must include the date of service, the service or activity provided, the arrival and departure time of each client to and from the program, the amount of service delivered, and a staff signature. Documentation must be present during the period for which services were billed to support that services were delivered, or payment in full will be retracted. If documentation is present but the number of units of service delivered does not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

The reviewer determines that progress notes for psychosocial rehabilitation services are completed at least monthly.

<u>Crisis Intervention (H0036)</u>

Admission to Service Was Appropriate

The reviewer confirms, through review of the documentation, that the client was experiencing an acute mental health dysfunction, and that immediate services were necessary due to a marked reduction in the client's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

Medical or Clinical Necessity

There must be documentation of immediate mental health care with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive setting.

Services Provided By Qualified Provider

Services must be provided by a DMHMRSAS-licensed outpatient program. This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service.

Short-Term Counseling Meets Service Model Criteria

- An ISP is not required for emergency services. An ISP is required for scheduled short-term counseling.
- The short-term counseling contacts must occur within 30 days of the first face-to-face crisis contact.
- If other clinic services are billed while the individual is receiving Crisis Intervention Services, documentation must clearly support the separation of the services with distinct treatment goals.

Delivered Services Consistent with Invoices

The reviewer determines whether the type and units of service recorded on the DMAS billing report match the documented services as noted in the client record. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted. If documentation is present but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

The case documentation must clearly indicate the occurrence of face-to-face contact with the client.

Intensive Community Treatment (H0039)

Admission to Service Was Appropriate

Documentation must demonstrate that the recipient is at high risk for psychiatric hospitalization, or for becoming or remaining homeless, needing intervention by the mental health or criminal justice system due to inappropriate social behavior, or is best served in the community. The individual must also have a history of a need for intensive mental health treatment.

Services Provided By Qualified Provider

The agency must be licensed by DMHMRSAS as a provider of intensive community treatment services or as a program of assertive community treatment. This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service.

Meets Service Model Criteria

- Assessment by a QMHP or a LMHP which authorizes the service.
- Re-assessment and re-authorization by a QMHP for continuation of services.

- A signed and dated ISP initiated at admission and fully developed by a QMHP and approved by the LMHP within 30 days of service initiation, which addresses the individual's need for the services as determined in the assessment.

- Verify that no concurrent billing for mental health clinic services, crisis stabilization, or case management has occurred. If concurrent billing has occurred, payment for mental health clinic services, crisis stabilization, or case management will be retracted for the period that ICT was also provided. ICT services may be billed if the consumer is brought to the clinic by ICT staff to see the psychiatrist. Documentation to support this intervention must be in the consumer's clinical record.

Delivered Services Consistent with Invoices

The reviewer determines that the type and units of service recorded on the DMAS billing report match the documented services as noted in the client record. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted. If documentation is present but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

The case documentation must have a daily log and at least a weekly note documenting progress toward goals and objectives.

<u>Crisis Stabilization (H2019)</u>

Admission to Services was Appropriate

Documentation must demonstrate that the recipient is in acute crisis of a psychiatric nature and at risk for psychiatric hospitalization.

Medical or Clinical Necessity

There must be an acute crisis which puts the individual at risk of psychiatric hospitalization. The individual must exhibit at least two of the following: difficulty in maintaining normal interpersonal relationships or ADLs; inappropriate behavior necessitating immediate interventions; or deficits in cognitive abilities resulting in inability to recognize personal safety issues.

Services Provided by Qualified Provider

This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service. Review of facility and staff licensure must comply with provider requirements.

Meets Service Model Criteria

- Documentation of psychiatric assessment, medication evaluation, treatment plan (including the expected length of service provision), and individual and group counseling.
- A face-to-face assessment, which authorizes the service, is documented, signed, and dated. The assessment must be performed by a QMHP, a certified pre-screener, or a LMHP.
- The assessment and authorization must be reviewed and approved by a LMHP within 72 hours of the assessment.
- A QMHP, certified pre-screener, or LMHP must develop an ISP within 10 business days of the approved assessment or re-assessment.
- Medication management visits may be reimbursed while an individual is receiving Crisis Stabilization Services. Documentation must clearly support the separation of the services with distinct treatment goals.

Delivered Services Consistent with Invoices

The reviewer determines whether the type and units of service recorded on the DMAS billing report match the documented services as noted in the client record. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted. If documentation is present but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing. If clinic option services were billed concurrent with this service, payment in full will be retracted.

The case documentation must have daily notes, a log of time spent, and documentation of progress toward goals and objectives.

Mental Health Support (H0046)

Admission to Service Was Appropriate

Documentation must demonstrate that the client has experienced mental, behavioral, or emotional illness resulting in significant functional impairments in major life activities.

Medical or Clinical Necessity

Mental health support services are training and support that enable individuals to achieve and maintain community stability. The individual must exhibit at least two of the following: difficulty in maintaining normal interpersonal relationships or ADLs; inappropriate behavior necessitating immediate interventions; or deficits in cognitive abilities resulting in inability to recognize personal safety issues.

Services Provided by Qualified Provider

Providers must be licensed by DMHRMSAS as a provider of Supportive In-Home Services, Intensive Community Treatment, or as a program of Assertive Community Treatment. This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service.

Meets Service Model Criteria

- An assessment, which documents the need for the service, must be done by a QMHP or a LMHP. The assessment must be completed within 30 days of admission. If the QMHP performs the assessment, it must be signed by the LMHP within 30 days of the beginning of service as being in need of the service.

- A signed, dated, and fully developed ISP by a QMHP or LMHP must be completed within 30 days of admission to the service. It must indicate the supports and services to be provided and the goals and objectives to be accomplished.

- Every three months, the LMHP or QMHP must review, modify as appropriate, and update the ISP. The ISP must be rewritten at least annually.

Delivered Services Consistent with Invoices

The reviewer determines whether the type and units of service recorded on the DMAS billing report match the documented services as noted in the client record. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted.

If documentation is present but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

<u>Substance Abuse Treatment for Pregnant and Postpartum Women - Residential (H0018, Modifier HD) / Day Treatment (H0015 Modifier HD)</u>

Admission to Service Was Appropriate

- Documentation of pregnancy, use of alcohol or drugs, and history of treatment.

- Documentation of assessment and criteria are met for Level III.3 or Level III.5 for Residential Treatment or Level II.1 or Level II.5 for Day Treatment.

Meets Service Model Requirements

There must be a review of records for a contract with an OB/GYN and an agreement with a high-risk pregnancy unit of a tertiary care hospital. Records must document:

- Access to services either through contract or agency staff.
- Non-medical supervision by a qualified substance abuse professional.
- That the ISP was developed by a qualified substance abuse professional involving the woman, appropriate significant others, and representatives of appropriate service agencies. For Residential Treatment, it must be developed within one week of admission and reviewed and updated every two weeks. For Day Treatment, the ISP must be developed within 14 days of admission and reviewed and updated every four weeks.
- Authorization following face-to-face evaluation/diagnostic assessment within 30 days prior to admission and re-authorized every 90 days. For Residential, re-authorization must be documented after any unauthorized absence of less than 72 hours; if unauthorized absence lasted more than 72 hours, service is terminated. For Day Treatment, re-authorization also must be documented after any absence of five consecutive days without staff permission. Day Treatment is terminated if two five-day episodes occur without authorization or one absence exceeding seven (7) days without prior authorization.
- That the professional authorizing services is not the same professional who is providing non-medical clinical supervision.
- Therapeutic face-to-face contact directly related to the ISP at least twice per week for Residential Treatment and at least once per week for Day Treatment.
- An obstetric assessment within two weeks following Residential admission and within 30 days following admission to Day Treatment.

Services Provided By Qualified Provider

- For Residential Treatment, the agency must be licensed by DMHMRSAS as a provider of residential substance abuse.
- For Day Treatment, the agency must be licensed by DMHMRSAS as an Outpatient Substance Abuse or Substance Abuse Day Treatment provider.
- This review is to ensure that the agency is licensed by DMHMRSAS, and that appropriate staff conduct the assessment or evaluation, develop the ISP, and deliver the service.

Delivered Services Consistent with Invoices

The reviewer determines whether the type and units of service recorded on the DMAS billing report match the documented services as noted in the client record. If there is no documentation during the period for which services were billed to support that services were delivered, payment in full will be retracted.

If documentation is present but the number of units of service delivered do not match the units of service billed, a billing adjustment is required to correct instances of over-billing.

Mental Health Case Management (H0023)

Admission to Service Was Appropriate

The client must be eligible and appropriate to receive case management (CM) funded under Medicaid. That is, individuals must meet the classification criteria for one of the three targeted population groups. The classification criteria for serious mental illness, serious emotional disturbance, or youth at risk of serious emotional disturbance are those contained within the DMHMRSAS definitions of these population groups.

For the individual to be eligible to receive case management billed to Medicaid, there must be evidence in the clinical record that classification criteria are met. This information (such as the diagnosis, level of disability, and duration of the illness to support "serious mental illness") must be supported by other clinical documentation that may include, but is not limited to, the following:

- A physician's diagnosis;
- Copies of the hospital discharge summaries;
- Reports/referral information from other agencies involved with the client/family;
- A social/medical history; and
- An employment/school history.

That is, the results of the documented "diagnostic study of the client" must support the classification of the individual as a member of one of the target groups.

Medical or Clinical Necessity

This service is applicable only for new referrals to allow for up to 30 days of Medicaid reimbursement during which time the case manager determines the need for ongoing case management, and either formulates an ISP or terminates the client from case management services. Financial eligibility for Medicaid services must be determined before billing can occur.

The referral/assessment information must be documented in the clinical record. This may be on an intake/assessment form or written intake evaluation report, in a written chronological intake note, or other type of documentation. This documentation must have been based upon a face-to-face contact with the client. That is, billing cannot occur before face-to-face contact with the client has occurred.

The referral/assessment information must include both of the following: (1) evidence that supports the classification of this individual in one of the three targeted case management groups (that is, the individual must meet the classification criteria for serious mental illness, serious emotional disturbance, or youth at risk of serious emotional disturbance before billing can be initiated); and (2) evidence that would substantiate the need for case management services.

ISP indicates a need for "active" case management.

- An active client for mental health case management shall mean an individual for whom there is a ISP in effect which requires, **at least monthly,** direct or client-related contacts, communication, or activity with the client, family, service providers, or significant others including a minimum of one face-to-face contact every 90-day period with a 10-day grace period. Billing can be submitted only for months in which direct or client-related contacts, activity, or communications occur. A single telephone call is not sufficient.

- There shall be no maximum service limits for case management services except case management services for individuals residing in institutions (including acute care hospitals and nursing facilities). For these individuals, reimbursement for case management shall be limited to one month immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two outpatient stays and pre-discharge periods (i.e., two months) in 12 months.

- Reimbursement for case management services for individuals under age 64 who are in an Institution for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and has more than 16 beds.

- The results of an assessment process must be kept in the client's record. The assessment process must provide a basis for determining the client's current and potential strengths, weaknesses, and service/support needs, using formal or informal, or both, evaluation information and techniques.

- An ISP, which documents the client's needs for services and supports, must be kept in the client's record.

- The ISP should indicate, in specific terms, the activities of the case manager. For each case management objective, the following information should be stated: why the objective is needed (a problem/need statement); strategies for service intervention; the person responsible for the service intervention; a target date for accomplishment of the objective; and the planned frequency of staff activity.

- The type, number, and frequency of case management contacts projected on the ISP should be related to the consumer needs as shown during the assessment process and the complement of services received. The ISP should state an adequate number of objectives for case managers to justify a minimum of one face-to-face contact with the client each 90-day period and monthly activity, contact, or communication.

- For clients in service for 30 days or more, if an ISP is not present in the clinical record or if the ISP does not demonstrate a need for case management services, payment in full will be retracted.

Services Provided by a Qualified Provider

The provider must be licensed as a provider of case management services.

A sample of personnel records, or other forms of verification indicating that the knowledge, skills, and abilities requirements are met for each case manager, will be reviewed during the on-site UR to determine compliance with the knowledge, skills, and abilities (KSAs) established by DMHMRSAS. If the required qualifications are not met, payment will be retracted.

The individual providing case management services is not required to be a member of an organizational unit that provides only case management. The case manager may be organizationally associated with a residential, day support, or other licensed program. The case manager who is not a member of the organized case management unit must possess a job description that describes case management activities as job duties, must provide services as defined for Targeted Case Management (TCM), and must comply with the service expectations and documentation requirements as required for organized case management units.

Delivered Services Consistent with Service Plan

To substantiate the "active" status of the client and support billing for TCM, the clinical record must contain documentation of at least monthly activity and, at a minimum, one face-to-face contact with the consumer each 90-day period.

This contact must be clearly documented in the client's record as a face-to-face meeting.

For purposes of this requirement, the face-to-face contact must be with the consumer. Contact with family members, significant others, and providers may not substitute for client contact.

The case management documentation should support that the services delivered are relevant to the goals and objectives of the ISP.

The ISP must document the need for case management, and the case manager must review the ISP at least every three months to assure that the identified needs are met and the required services are provided. The first quarterly review will be due by the last day of the third month from the effective date of the ISP. However, a grace period of one month will be given to complete the review. The next quarterly review will be based on the month the previous quarterly review was due and not on the date when the review was actually completed in the grace period. This update should include a statement/comment on the current status of the client in relationship to all services and supports being provided. That is, **this is a review of the comprehensive ISP, not just of the progress toward case management objectives.**

The case management objectives should be modified, accomplished, or added at the quarterly review as determined by the client status.

The following documentation may serve as evidence of the required quarterly review:

- A completed ISP review form which updates the status of the client; and
- An entry in the clinical record which indicates an ISP review and which updates the status of the client.

A date alone indicating that the ISP was reviewed will not suffice to meet this requirement. Quarterly review progress notes or forms must include a statement of the client's current status (progress toward the goals and objectives) and the status of the ISP, and must be signed by the case manager who completed the review. A checklist format which also allows space for necessary narrative comment may be used to meet this requirement.

There must be no more than 365 days between the effective dates of an individual's annual ISP. The current ISP may not be an "old" ISP that has a new date written on it. The ISP must be re-written annually.

The effective date of an ISP for a new client must not be more than 30 days following the first face-to-face contact with the client and the initiation of service. There is a 30-day period from the date of the first client contact during which the ISP must be developed with the client and finalized.

Delivered Services Consistent with Invoices

To substantiate billing for each month, the client's record must contain documentation of minimal monthly contact, communication, and/or activity with the consumer, family, service providers, or other organization or individuals on behalf of the client. These contacts and service activities must be clearly documented as a case management service.

The monthly units of service recorded on the DMAS billing reports will be compared to case management activities documented in the clinical record. If there is no documentation during the period for which services were billed to support that services were delivered during this period, payment in full will be retracted.

The units of service billed to DMAS may be substantiated by the following type of record entries:

- Per "contact" or per "activity" record entries; or
- Weekly or monthly summaries of the case management services, which can be tracked through a contact log or staff activity sheet that briefly notes the contact.

The major components of case management services include the following types of activities:

- Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment but does include the referral for such assessments);
- Linking the individual to the services and supports specified in the ISP;
- Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources;
- Coordinating services and service planning with other agencies and providers involved with the individual;
- Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills and to use vocational, civic, and recreational services;
- Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;
- Follow-up and monitoring to assess ongoing progress and ensuring that the services are delivered; and
- Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

RECONSIDERATIONS AND APPEALS

Payment to providers may be denied when the provider has failed to comply with established federal and state regulations or policy guidelines.

The provider has the right to request reconsideration of denials. The request for reconsideration and all supporting documentation must be submitted within 30 days of receipt of the UR report to:

Manager, PAUR (Prior Authorization Utilization Review) Section
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the provider with a written response to the request for reconsideration. If the denial is upheld, the provider has the right to appeal the reconsideration decision in accordance with procedures outlined in the "Reconsideration and Appeals of Adverse Actions" section of Chapter II of this manual.